# Prior Authorization Request Form for Zynteglo (betibeglogene autotemcel)

**FAX this completed form to (844) 205-3386**
**OR Mail requests to: Pharmacy Department | 5 River Park Place East, Suite 210 | Fresno, CA 93720**
**OR Prior authorization may be completed at https://www.covermymeds.com/main/prior-authorization-forms/**

| Member name: | | Member ID#: | Member DOB: |
|---|---|---|---|
| Prescriber name: | | | Prescriber NPI: |
| Prescriber address (street/city/state/zip): | | | |
| Prescriber specialty: | | Prescriber phone: | Prescriber fax: |
| Office contact name: | | Office contact phone: | Office contact fax: |
| Billing provider name: | | | Billing provider NPI: |
| Billing provider address: | | | |

| Drug name: **Zynteglo** | Member's weight (kg): | Dose: ________________ x $10^6$ CD34+ cells/kg |
|---|---|---|
| Place of service: | | Anticipated date of infusion: |
| Diagnosis *(submit documentation)*: | | Dx code (*required*): |

**Check all that apply and submit documentation (e.g., recent chart/clinic notes, diagnostic evaluations, test results, etc.) for each item.**

- ☐ Has NOT received prior gene therapy.
- ☐ Has NOT received a prior allogeneic hematopoietic stem cell transplant.
- ☐ Has genetic testing confirming the diagnosis of β-thalassemia.
- ☐ Has a history of at least 100 mL/kg/year or 8 transfusion episodes/year of packed red blood cell transfusions in the prior 2 years.

**PLEASE FAX COMPLETED FORM WITH SUPPORTING CLINICAL DOCUMENTATION TO (844) 205-3386**

| **Prescriber Signature:** | **Date**: |
|---|---|
| | |

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PA Department will respond via fax or phone within 24 hours. Requests for prior authorization (PA) requests must include member name, ID#, and drug name. Please include lab reports with requests when appropriate.